Public Employees Benefits Board

Life Insurance Evidence of Insurability Form

- Type or print clearly in ink.
- Return to agency or ReliaStar Life Insurance Co.

SECTION 1:

Social Security Number	Last Name	First Name	Middle Initial	Agency/Division

House Number	Street Address	Apt./Unit Number	Phone: Work ( ) Home ( )	Birth Date (MO/DAY/YR)	☐ Male ☐ Female

City	State	ZIP Code + 4	Do you or your spouse/domestic partner smoke? ☐Yes ☐No If no, complete and sign Nonsmoker Certification section.

SECTION 2: EMPLOYEE: Evidence of insurability

(To be completed only when applying for Part C or Part D more than 60 days after original insurance eligibility date, OR when applying for more than $50,000 Part D within 60 days of original eligibility date.)

Employee _____ Height _____ Weight _____ Sex _____

Occupation _____ Birth Date _____ Birthplace _____ Marriage/Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years? ☐ Yes ☐ No

2. Have you ever had:
   - A. High Blood Pressure, Heart Disease, or Arteriosclerosis? ..... ☐ Yes ☐ No
   - B. Mental Illness, Stroke, or Epilepsy? ..... ☐ Yes ☐ No
   - C. Cancer, Diabetes, or Nephritis? ..... ☐ Yes ☐ No
   - D. Any problems with the back or spine? ..... ☐ Yes ☐ No
   - E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ..... ☐ Yes ☐ No

3. Are you now unable to work full time because of any disease or disorder? ..... ☐ Yes ☐ No
4. Do you take regular medication for treatment or control of any condition or ailment? ..... ☐ Yes ☐ No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment? ..... ☐ Yes ☐ No

Injuries, Diseases, Disorders, and Operations	Month, Year	Duration	Result	Names and Addresses of Health Care Providers Consulted

SECTION 3: SPOUSE/DOMESTIC PARTNER: Evidence of insurability

(To be completed only when applying for Part B Basic or Part B Supplemental Spouse Life more than 60 days after original insurance eligibility date, OR when applying for more than $25,000 Part B Supplemental Spouse Life within 60 days of original insurance eligibility date.)

Are you a state employee? ☐ Yes ☐ No
If yes, are you also applying for coverage through your agency? ☐ Yes ☐ No

NOTE: The employee will always be designated as beneficiary for spouse/domestic partner and dependent life insurance.

Spouse/Domestic Partner _____ Height _____ Weight _____ Sex _____

Occupation _____ Birth Date _____ Birthplace _____ Marriage/Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years? ☐ Yes ☐ No

2. Have you ever had:
   - A. High Blood Pressure, Heart Disease, or Arteriosclerosis? ..... ☐ Yes ☐ No
   - B. Mental Illness, Stroke, or Epilepsy? ..... ☐ Yes ☐ No
   - C. Cancer, Diabetes, or Nephritis? ..... ☐ Yes ☐ No
   - D. Any problems with the back or spine? ..... ☐ Yes ☐ No
   - E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ..... ☐ Yes ☐ No

3. Are you now unable to work full time because of any disease or disorder? ..... ☐ Yes ☐ No
4. Do you take regular medication for treatment or control of any condition or ailment? ..... ☐ Yes ☐ No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment? ..... ☐ Yes ☐ No

Injuries, Diseases, Disorders, and Operations	Month, Year	Duration	Result	Names and Addresses of Health Care Providers Consulted

Authorization and acknowledgment–Please read and sign below:

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau (MIB), Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, or any non-medical information as they apply to me, my spouse/domestic partner, or any of my children who are to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations–42CFR Part 2. I may revoke this authorization as it applies to any information protected by this Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or in any way relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Insurance Information Practices Notice and Notice Regarding MIB, Inc. (on the back of the *Evidence of Insurability Form*).

Date	Employee's Signature *(required)*	
Date	Spouse/Domestic Partner's Signature *(if applying)*	Spouse/Domestic Partner's Social Security Number *(if applying)*

Mail completed form to:
ReliaStar Life Insurance Co., P.O. Box 20, Route 7325, Minneapolis, MN 55440-6020

HCA 50-645B (11/02)

For Agency Use
Date sent to carrier:
_____
Date / Initials

ReliaStar Life Insurance Company
Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Evidence Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See “Notice Regarding MIB, Inc.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with ReliaStar Life or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB’s file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB’s information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB’s phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.